West Virginia Department of Health and Human Resources
Bureau for Behavioral Health and Health Facilities
Detail Statement of BHHF - Administered Target Funding

GRANTEE NAME: _____ **BUDGET PERIOD ENDING:** _____

ORIGINAL ☐ **REVISION** ☐ **REVISION #** ☐

ASSIGNED PROGRAM NAME: _____ **DATE** 1/0/1900
STATE ASSIGNED ACCOUNT NUMBER: _____
CURRENT YEAR ALLOCATION: _____

*DIRECT COSTS	BHHF Funds	**OTHER Funds	TOTAL
A. PERSONNEL (DESCRIBE POSITIONS)			
1.			$0
2.			$0
3.			$0
4.			$0
5.			$0
Category Subtotal:	$0	$0	$0
B. FRINGE BENEFITS			
1. Pension			$0
2. Health Insurance			$0
3. FICA			$0
4. Unemployment Insurance			$0
5. Workers Compensation			$0
6.			$0
Category Subtotal:	$0	$0	$0
C. Equipment (Describe):			
1.			$0
2.			$0
3.			$0
Category Subtotal:	$0	$0	$0
D. SUPPLIES			
1. DIRECT OFFICE SUPPLIES			$0
2. GENERAL PROGRAM SUPPLIES			$0
3. HOUSEKEEPING SUPPLIES			$0
4.			$0
5.			$0
6.			$0
Category Subtotal:	$0	$0	$0
E. CONTRACTED SERVICES (DESCRIBE):			
1.			$0
2.			$0
3.			$0
Category Subtotal:	$0	$0	$0
F. CONSTRUCTION (Special Permission)			$0
G. OTHER			
1. DIRECT STAFF TRAVEL			$0
2. RENT			$0
3. DEPRECIATION			$0
4. REPAIRS & MAINTENANCE (vehicle)			$0
5. REPAIRS & MAINTENANCE (facility)			$0
6. REPAIRS & MAINTENANCE (Equipment)			$0
7. INSURANCE (property, liability, etc.)			$0
8. UTILITIES			$0
9. PHONE			$0
10. HOUSEKEEPING SERVICES			$0
11.			$0
12.			$0
13.			$0
Category Subtotal:	$0	$0	$0
TOTAL DIRECT COSTS (SUM OF A - G)	$0	$0	$0

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	BHHF Funds	OTHER Funds	TOTAL
1. TOTAL DIRECT COSTS (From Prior Page)	$0	$0	$0
2. *** BHHF INDIRECT COST BASE AMOUNT	$0		
3. ****INDIRECT COST RATE	0.00%		
4. *****INDIRECT COST AMOUNT (Base X Rate)	$0	$0	$0
5. TOTAL BHHF COSTS (BHHF Direct + BHHF Indirect)	$0		
6. TOTAL OTHER COSTS (Other Direct + Other Indirect)		$0	
7. ANTICIPATED PROGRAM INCOME EARNED		$0	
8. GRANTEE / OTHER SOURCE SUPPLIED PORTION		$0	
9. TOTAL PROGRAM BUDGET (Total BHHF Funds + Total Other Funds)			**$0**

BRIEF PROJECT DESCRIPTION:

FUNDING/SOURCE: (If this program is supported by Other Funds, what is the projected source and amount of those funds? List all projected funding sources and amounts.)

NOTES:

*In order to be considered as direct costs for target funding purposes, these costs must also be shown as direct costs on the Provider's indirect cost plan, or as client program costs on the Medicaid Cost Report submitted to the DHHR.

**Any anticipated amounts of program income should be included in the budget for Other Funds.

*** BHHF does not permit for indirect costs to be applied to equipment and capital expenditures. Providers that utilize such expenditures as part of their indirect cost plan must remove BHHF funded equipment and capital expenditures when determining their allowable indirect cost base.

****In order for a Comprehensive Mental Health Center to be eligible to charge indirect costs, these providers must have an approved indirect cost plan. Indirect costs may only be charged at the rate calculated in the approved plan. However, please note that notwithstanding the existence of an approved indirect cost plan, some federal grants restrict or cap the amount of indirect cost chargeable to the grant, and in some cases BHHF may choose to restrict costs chargeable to the grant.

Smaller providers (not comprehensive behavioral health care centers) may charge an indirect cost of up to 15% on STATE Funds Only,if these costs are not recouped elsewhere. Providers must have an approved indirect cost plan in order to charge indirect costs to any Federal Grant. BHHF may choose to restrict the amount of indirect costs charged to grants based upon the program.

***** Please note that the Indirect Cost rate for Other Funds May be (or may need to be) higher than the actual rate if equipment and expenditures are generally included in the organizations indirect cost rate.

Prepared By: _____ **DATE** 1/0/1900

Telephone Number: _____

BHHF USE ONLY

DIVISION DIRECTOR APPROVAL _____ **DATE** _____

DEPUTY COMMISSIONER APPROVAL _____ **DATE** _____